PREVENTION PARTNERSHIP PROVIDER ENROLLMENT

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 58496 (12-2011)

Provider I.D. Number

Centers for Disease Control and Prevention **CFDA No. 93.268**
Grant Number H23/CCH822552-01-1 **Immunization Grants**
Immunization and Vaccines for Children Grant **Budget Period 2008**

To participate in the Prevention Partnership Program and receive state and federally procured vaccine provided to my facility at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this medical office, group practice, managed care organization, community/migrant/rural clinic, health department or other health delivery facility of which I am the medical director or equivalent:

1. I will screen patients at all immunization encounters for eligibility and administer Vaccines For Children (VFC) or state-supplied vaccine only to individuals who meet the following critieria:
    a. Is 18 years of age or younger
    AND
    b. Is VFC vaccine-eligible
        i. Is an American Indian or Alaska Native.
        ii. Is enrolled in Medicaid.
        iii. Has no health insurance.
        iv. Is underinsured (a child whose health insurance benefit plan does not cover a particular vaccine). Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) or providers with a Letter of Agreement with a FQHC are the only providers who may vaccinate underinsured children.
    OR
    c. Is considered state-supplied vaccine-eligible based on the most current North Dakota Vaccine Coverage Table.
2. I will comply with the immunization schedule, dosage, and contraindications that are established by the ACIP and included in the VFC program unless:
    a. In my medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate.
    b. The particular requirements contradict state law, including those pertaining to religious and other exemptions.
3. I will maintain all records (including patient screening forms, temperature logs, etc.) related to the VFC program for a minimum of three years and make these records available to public health officials including the North Dakota Department of Health (NDDoH), the North Dakota State Auditor or the Auditor's designee, or U.S. Department of Health and Human Services (DHHS) upon request.
4. I will immunize eligible children with VFC or state-supplied vaccine at no charge to the patient for the vaccine.
5. I will not charge a vaccine administration fee to VFC children that exceeds the administration fee cap of $13.90 per vaccine dose. I will accept the reimbursement for immunization administration set by the state Medicaid agency for vaccine administered to children enrolled in Medicaid.
6. I will not deny administration of a VFC or state-supplied vaccine to a patient because the child's parent or guardian or the patient is unable to pay the administration fee**.**
7. I will distribute the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Compensation Act (NCVIA) which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
8. I will comply with the requirements for ordering, vaccine accountability, and vaccine management as outlined in the current North Dakota Immunization Program Vaccine Management Plan, Fraud and Abuse Policy, and Vaccine Loss Policy. I agree to operate within the VFC program in a manner intended to avoid fraud and abuse.
9. I will document demographic, VFC-eligibility, and immunization information on a Vaccine Administration Record (VAR) or Patient Eligibility Screening Form and in the North Dakota Immunization Information System (NDIIS).
10. I will allow NDDoH staff to conduct site visits for review of vaccine administration procedures, vaccine storage procedures and coverage level assessments.
11. The NDDoH may terminate this agreement at any time for failure to comply with these requirements, or I may terminate this agreement at any time for any reason. If I terminate, I agree to return all unused VFC and state-supplied vaccine.
12. I agree that all records, regardless of physical form, and the accounting practices and procedures of my facility relevant to this agreement are subject to examination by the North Dakota Department of Health, North Dakota State Auditor or the Auditor's designee.
13. Should my staff, representative, or I access VTrckS, I agree to be bound by CDC's terms of use for interacting with the online ordering system. I further agree to be bound by any applicable federal laws, regulations or guidelines related to accessing a CDC system and ordering publicly funded vaccines.
14. In advance of any VTrckS access by my staff, representative or myself, I will identify each member of my staff or representative who is authorized to order vaccines on my behalf. In addition, I will maintain a record of each staff member who is authorized to order vaccines on my behalf. If changes occur, I will inform CDC within 24 hours of any change in status of current staff members or representatives who are no longer authorized to order vaccines, or the addition or any new staff authorized to order on my behalf. I certify that my identification is represented correctly on this provider enrollment form.

Provider Signature (must be M.D. or D.O.):	Date:

This record is to be submitted and kept on file at the North Dakota Department of Health Immunization Program and must be updated in accordance with state policy.

FOR STATE USE ONLY	**Immunization Program Representative:**	**Date Certified:**

PROVIDER ENROLLMENT - ADDITIONAL PROVIDERS WITHIN PRACTICE
NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 58494 (01-2011)

Last Name/First Name/ Middle Initial	Medical License Number	Medicaid Provider Number	Title (MD, DO, ND, NP, PA) Note: Provider must have prescription writing privileges	Specialty (Pediatrics, Family Medicine, General Practitioner, Other-Please Specify)

For State Use Only:	
Immunization Program Representative:	Date Certified for Prevention Partnership: